CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:
2008 Physician Quality Reporting Initiative – Participation by the American College of Physicians

Conference Leaders: Michael Rapp, MD (CMS) & Michael Barr, MD (ACP)
Moderator: Natalie Highsmith (CMS)

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3:30 pm ET

Operator: Good afternoon. My name is (Laurie) and I'll be your Conference Facilitator today.

At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Service Special Open Door Forum on the 2008 Physician Quality Reporting Initiative Participation by the American College of Physicians.

All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press Star then the number 1 on your telephone keypad.

If you would like to withdraw you question, press the Pound key.

At this time I'll turn the conference over the Natalie Highsmith. Please go ahead.

Natalie Highsmith: Thank you (Laurie) and good day to everyone. And thank you for joining us for this Special Open Door Forum.

(CMS) is hosting this Special Open Door Forum along with the American College of Physicians to discuss participation in the 2008 Physician Quality Reporting Initiative.

The purpose of this Open Door is to encourage PQRI participation and provide steps that physicians can use to collect and report quality data to be eligible for incentive payments.

We sent out a list serve notice to our participants yesterday informing them of the slides that are posted for today's presentation. And if you did not receive that, the Web link is www.cms.hhs.gov/pqri.

And on the left-hand side, you will see a link that says (CMS) sponsored call. And you would scroll down to the bottom of the page under the related links outside (CMS).

And you would click on that link and the slides should pop-up right there. And those would be the slides for today's presentation.

I will now turn the call over to Dr. Michael Rapp who is the Director of the Quality Measurement and Health Assessment Group in the (CMS) Office of Clinical Standards and Quality. Dr. Rapp?

Michael Rapp: Thank you Natalie. Well it's a pleasure to be co-hosting a call with the American College of Physicians dealing with the Physician Quality Reporting Initiative.

We think that first the PQRI Program is very broad and covers really all of the different types of practices that there are and multiple different types of professionals, and their different kinds of work.

But the - from a practical standpoint as you participate in PQRI, each practice is different in how they organize their practice. How do they organize the reporting information will be different for each different type of specialty and practice.

So we think it's very important to have individuals that have some practical experience with it. And so that's why we've sought to have some Special Open Door Forums that deal with the particular types of practice.

Internal medicine of course is a very large specialty. And there are many measures that physicians in internal medicine can report on. And we're hopeful that this Open Door Forum with the participation of the American College of Physicians will be helpful to practicing internists as they seek to participate in PQRI.

Before I turn the call over to our participants, I would like to reflect on where we are with the Physician Quality Reporting Initiative. I think you're all aware that this first started in 2007. And it was based upon a statute that Congress passed toward the end of 2006.

So, the participation for 2007 was for the second half of the year from July 1, 2007 until December 31, 2007. The physicians could submit data up until the end of February of 2008. And ultimately we needed to calculate the incentive payments that would be available to the physicians.

And we also thought it was very important to have confidential feedback reports available to them.

Some of you may have listened in to our - some of our other calls where we described how that would work, but we're very pleased to note that yesterday the payments - the incentive payments started. They will be completed by the end of this month.

And in addition, access to the confidential feedback reports became available yesterday.

So that's an important milestone in the Physician Quality Reporting Initiative. It required a lot of work on a lot of people's parts. Particularly - including such organizations as the American College of Physicians who've been active in the development of quality measures, and helped guide us in the infrastructure necessary to do this.

So, it's a high point for us. But although we've completed really 2007, we're also in the middle of 2008 as individuals begin - or can participate and cement quality measures in 2008.

In particular, starting July 1, 2008 we've had a new reporting period that's available that - for claims-based measures physicians can record unmeasured groups. And you'll hear more about that on this call as well.

So again, we're quite excited about where we are with PQRI and the level of participation. We did have a Press Release issued today that was sent out, so you'll probably - many of you'll be seeing that. So, again, it's a high point for us today.

So now, let's switch to what the main purpose of this is. And that is to assist internists in particular in participating in PQRI.

And as part of our Open Door Forum Call today, we have several distinguished guests that will be us. First of all, Dr. Michael Vague who is the Vice President for Practice Advocacy and Improvement for the American College of Physicians.

Its focus is on public policy related to the patient-centered medical home and quality improvement practice re-design to help information technology. And he has overall responsibility for the Colleges' Regulatory and Insurer Affairs Department Practice Management Center and Medical Laboratory Evaluation Program.

So we're very pleased to him. He will give us some general information. And then in addition, Brett Baker who is the Director of Regulatory and Insurer Affairs for the American College of Physicians will be speaking as to the overall PQRI Program as well.

But then what I think will be particularly valuable for the callers - for the listeners on this call would be the input that we'll be able to receive here from two practicing physicians that have had experience with the PQRI Program, and can give you practical information.

The first is Dr. (Rodney Hornback) who's a practicing internist, but Dr. (Hornback) is in full-time clinical practice in Connecticut, and helped our - share his experiences with you.

Received his MD from the University of Pittsburgh, and did his internship and residency in Internal Medicine at the University Health Center of Pittsburgh.

In addition, we have participating in the call Dr. (Mary Newman). She is a practicing Internist in Lutherville, Maryland. She's a graduate of Creighton University Medical School, and did her residency at Johns Hopkins.

Again, both of these individuals have practical experience with participation in PQRI. And I'm sure you're looking forward to as I am in having them share their experiences and give you some practical guidance on participating in PQRI.

So, without further a due, I will turn the call now over to Dr. Michael Vague.

Michael Vague: Thank you Dr. Rapp. I appreciate the introduction. And thank you all of you who are joining the call.

I'm sure we have a varied level of experience on the call in terms of folks who are contemplating participating in PQRI. Those who've probably done a little bit, and those who may have already been involved and looking for an update.

So our slides in our presentation will cover most of this. I'll start with some background information and basic concepts. But the (nitty gritty) of the measurements and the way it's set up for 2008 will be covered by Brett Baker.

And as Dr. Rapp said, we'll give you some practical experience from two of our (ECP) Leaders who are involved as clinical practitioners and internists doing the PQRI Program.

So hopefully you have the slides here in front of you, and I'll start on of course Slide 2 - just the overall concept. I mean most of you are probably familiar with this, but the PQRI launches select quality measures that are important to your practice.

In other words, there are no post-scribed list of measures that you must report on, which is great. Because if you were going to do this, you compare the measurements that you want to do based upon the population that you're currently serving.

And, measure on clinical indicators that are of interest to you or patients from your practicing partners.

Up until I was re-establish a process in the practice to look at quality across your practice, and then continually improve. Which - the bottom line, that's really the goal for the program so that we achieve some quality improvements.

It has a design to be as least burdensome as possible by using claims codes on your current encounter form based upon the measures that you're using. So, while that might take some more in terms of setting-up, once it's there it should be able to flow fairly easily.

But we'll hear from Dr. (Newman) and Dr. (Hornback) about how they've done it. And then of course as Dr. Rapp mentioned, you will get feedback on this program ultimately.

So, where it is in real-time that you're getting these back as you're doing it, ultimately you're going to report as to how you did as compared to others.

There is opinions as Dr. Rapp mentioned. We'll go into a little bit more detail as to how this consulates the leader.

As I mention it, it's a process whereby you can really improve healthcare if you do this correctly. And take advantage of the reporting capabilities that are being delivered by (CMS).

If we go over to Slide 3, that's a little bit about the richness of the background. Dr. Rapp covered some of this. This is a follow on to a warrant enacted in December 2006 and the PQRI for 2007. It was a 1 1/2% bonus on all your claims for the trade-up of quality measures reported through July 1st and December 31st.

And it was a selection of 74 different measures. Not 74 different measures for internal measures in our primary care, but that represented measures all - I should say a lot of specialties.

The idea was to pick three - up to three and - three or more, but that the key was that you were to report on those three measures on 80% of the eligible encounters.

So if you had 100 encounters with diabetics and you picked a diabetes measure, you would need to report 80% of them or 80 of those patients - encounters.

And then reporting on a measure of - through claims code on a standard (CMS) claim form, and then (CMS) would do the analysis in terms of whether you met the baseline or the threshold recording requirements. And how much money it would do if you were awarded based upon their calculations.

If you go to Slide 4, this is sort of a representative PQRI quality measure geared towards patients with diabetes for whom you want to manage their LDL cholesterol.

And you'll note that the goal here is assessing. Again, the key here is just reporting what is. There isn't the cut-offs and you must have a cut-off of LDL below a certain number. But reporting on what the LDL is.

In this case, whether the LDL was less than 100, 100 to 129, or greater equal to 130, and then more modifiers as to whether this would or would not apply to the patient and variegate some of those leaders.

The assessment's to whether eligible patient is theirs based upon your (ICD) coding. That's important that your (ICD) codes are active and reflect the population or the patient visit that you - that occurred.

These would be encounters that are eligible for this kind of reporting, or those that occur in the office, nursing facility, home and (faciliary) services.

And then this last bullet is a little confusing. I sort of described this before, but essentially the number of encounters with patients who are eligible for a particular measure divided by the number of encounters - well I just messed up again.

And other times you report a measure on eligible patients based upon the encounters that are - that you've had for that particular measure. Again, if you have 100 diabetics coming in you would need to get to 80% of them if that was the measure you were picking, which it recorded this particular measure on.

Why don't we go to Slide 5? As Dr. Rapp indicated, intensive payments have already been calculated. And the Press Release today was actually fairly interesting.

It states that 56,700 health professionals participated. And more than $36 million was generated in terms of returns to those clinicians who participated. So I encourage you to look for the Press Release for more details.

The payments will be issues to Tax ID Numbers for all associated clinicians who earn the bonus. And that these are type of reports again referenced by Dr. Rapp - will start becoming available and are available for those who can access them right now.

And then (CMS's) mechanisms to help position the registration and the receipt of the report from technical systems.

On Slide 8, moving on to PQRI 2008 and some of the changes that are anticipated. In 2007, Congress passed a Law authorizing the continuation of the PQRI. And it has many of the same features of 2007 programs, such as reporting on codes for individual measures, up to three individual measures for at least 80% of eligible encounters. And again, a 1.5% bonus.

But there is some additional changes. Number one is the number of measures you could chose from expanded from 74 to 119. And among those were two structural measures related to e-prescribing and electronic health records, as well as some additional reporting options which (Bret) will get into in some more detail.

Moving on to Slide 7, I think I'll wrap up with the next three slides. In terms of why - why would you want to report for PQRI? And I short of took my head early in a presentation from the American College of Physicians perspective, we believe this is an opportunity for physicians and practices to

really focus in on quality for what clinical conditions that are important to the practice that you have.

It's an opportunity to use this model with some reimbursement to design processes in your proactive to track populations of patients with particular conditions.

Generate reports and quality codes for (CMS) to help you with. Get those reports back. See what the gaps and cure how you compare to others across the country. Promote team cure. Events by team members who take rolls and responsibilities to make this process more smoothly in your practice, and then generate quality improvements over time.

The quality codes that you're using for this Law, they may look onerous when you look at the whole range of them and the large number of measures. Once you hone in on the kinds of measures you want to measure - kind of measure you want to use based upon the population you serve, and start using them in practice.

Our experience and our expectation is that it would no be as troublesome as it might appear at first glance.

On Slide 8, we think this is an opportunity to get experience and quality improvements within your practice with some reimbursement tied to that.

And we do believe, and obviously it remains to be seen, but we do expect this type of quality reporting and incentives will be part of the reimbursement moving forward.

And this is an opportunity to get involved with this relatively early, and there also be with little risk.

We think that the PQRI is an opportunity to get this experience, translate into changes in practice.

And if you switch to Slide 9, there is a growing movement to have a patient-centered medical home.

And for those of you not familiar with that, this is sort of a model of changing practice to be more patient-centered and more focused on what patient need instruction processes within your practice.

To identify clinical conditions, use evidence-based guidelines, to promote better care, help your patients manage their own conditions, work with families, community-based organizations, to help the patient when their not in your office, introduce new access in communication opportunities and whether that's enhanced telephone access, secured email access, group visits, scheduled telephone visits.

The kind of things that patients have told us they like, and which we probably as physicians would like to deliver but in the current model become difficult.

As well, we're not there yet obviously. But the model does include performance-based compensation.

In the PQRI is a model of performance-based compensation. And as we do demonstration projects in the commercial sector for the medical home, the kinds of measures that the PQRI is looking at are the same measures that we're looking at in a demonstration project.

So again, this is an opportunity to sort of jump up and take advantage of this program, start making changes in the practice, start seeing how your practice is performing on particular quality measures of your choice, and getting reimbursed for it even as the changes around you are taking place. And get you better informed as to what's happening.

So with that, I'm going to turn it over to Brett Baker who is our Director of Regulatory and Insurer Payers. And he's going to get into a bit more specifics about the measures and the reporting opportunity here. Brett?

Brett Baker: Thank you Michael. And again, thanks to all of you who have dialed in to participate in today's call. We do want to talk - as Michael's job description stated, you kind of go on a time on the basis center medical home and quality improvement.

And we want to take the opportunity to mention that delivery model and the kind of traction that it's gotten the attention to it, and how that in different forces or movements can kind of align under the patient-centered medical home model as it's called.

You know, the accountability on the practice for quality - tracking quality or reporting quality measurement and improvement. So we think PQRI is a part of that, and there's a lot of synergy that's made some of these efforts that are already underway.

I do want to talk about your reporting options for 2008. You know, we are half way through the year now, but there's still plenty of opportunities to participate in the PQRI Program and earn your bonus for 2008.

(CMS) has expanded the options through new reporting periods and reporting methods. And as stated on Slide 10, you know, the reporting period can be the 12 month period or the full year of 2008, or it can be the last six months here of 2008.

There are a total of nine PQRI reporting methods. Three of those are claims-based reporting which Michael described. In the background, just stating these are just reporting quality measures on the claims for services that you're submitting to Medicare.

And then there are also six registry-based options. And that's a clinical registry where as - to which physicians will report information to be aggregated and analyzed.

And (CMS) is still kind of working out the details of this reporting option, and from which registries they'll be able to accept quality data, and how that kind of fits into earning the PQRI bonus.

So there's actually - it's going to be six options related to reporting registries. But we're going to focus on the remainder of this discussion on the claims-based reporting options. But at least in 2008, they will be the ones that are most acceptable to internists. We will briefly describe the reporting - the registry-based reporting options as well.

Moving on to Slide 11, you have three claims reporting options for 2008. One is for the entire 2008 recording period - 12 month period - January 1 through December 31 of 1008.

And to do that, to participate for the full 12 months you need to report on qualities - up to three quality measures. They'll be generally to say three for

internists. And so out of the 119 available measures, a number applicable to patients typically seen by internists, so we'd like to say that you'd report on up to, you know, at least three measures on 80% of the eligible patients, and that you need to report on those patients for the full year. And that's option one.

The second two options for clients-based reporting is for the last six months here of 2008. And one option is reporting a measure group, which we'll describe in more detail in a little bit.

But reporting on a measure group, which (CMS) had established four measure groups for common conditions on 15 consecutive eligible patients.

And another option would be reporting that a measure group for 80% of the eligible patients over the six month period. So essentially what that does is gives you that opportunity to still qualify for a bonus payment by recording a measure group. Even if you try to do the 15 consecutive patients, but somehow maybe missed one in there.

If you kind of continue to report on that measure group the remainder of the last six months of 2008, you still have an opportunity to earn a group for report - a bonus for reporting on a measure approved. So we will get into more detail on all of these options.

They're reporting on individual quality measures. And this is really the option that was available to you in the last six months of 2007. But if you have been doing that - but if you chose that option and have been doing reporting on three individual quality measures, but the sample measure we discussed earlier - the LDL cholesterol control measure.

If you're reporting on those individual measures and you have been, continue to do so for the remainder of the year.

What we would say is that if you're doing that and you are now in - and you also participated in 2007. Now that that feedback report is available from (CMS), that I'm sure you'll want to go access in addition to receiving your bonus payment that you hopefully qualified for.

We suggest that you use that experience or anything you can gleam from that information - from your 2007 participation to see if you want to make any adjustments process wise for your reporting in 2008.

Let me make a quick reference in the slides here on Slide 12, to some of the tools that are available to you to help you report on those individual quality measures.

The AMA jointly with (CMS) make available what they call data collection worksheets. And the Web site to the available through the AMA's Web site is listed in the slide.

These are very nice kind of worksheets. It's one page per quality measure. So if you select your measures you can go and you can access the sheet for each of those measures.

But (ACP) has made available - is a single, but one page front and back document that has - provides coding template for seven measures all on the one sheet or the one page for the measures that we kind of determined would be most applicable to general internal medicine.

So, you diabetes, your coronary heart disease and some geriatric measures. So on that, and one single page we provide you the ability to kind of circle the quality of measure codes for those quality measures, and, you know, facilitate your appropriate reporting that way.

As (Ed Larzario) alluded to the bonus payment for reporting for a full year in 2008 will be 1.5% of your total Medicare allowed charges for 2008.

And just based on some nationally available data for general internal medicine, you know, (ACP) has estimated - roughly estimated that amount to be about $3,000 - would be kind of a likely bonus for a general internists for full reporting in 2008.

So moving on to Slide 13, again, specific to individual reporting and individual quality measures. You may ask if you haven't started reporting on individual measures yet in 2008. If it's too late? And the answer to that is no.

And I'll admit that I was somewhat surprised when I look through the available measures - 119 measures, and those that we had identified as most relevant to internal medicine.

That over 30 of those measure that are very common to internal medicine practice, only that we reported on once in a 12 month period. And those do include diabetes measures, coronary heart disease and some geriatric measures. Again, so the really common measures.

This does require you to identify - have a systematic way to identify the patients who come into your office and have the conditions you select.

And so we will hear from, as was noted, our practicing physicians who are participating, to kind of understand how they have gone about doing this.

But this could be a registry that you use for tracking patients of certain conditions, or population management in your office. Or it can be a less sophisticated method.

There is - as I said, the measures that you can pick - or is that you can still report on in 2008, and by starting now are diabetes would be example. Which would be the three to chose would be (inflow) and (A1Cs). The LDL cholesterol and blood pressure.

There's also some screening measures. And we'll talk about these types of measures and the group measure contact shortly as well. But you can start a report on, even starting now, the flu vaccine measures and pneumonia vaccine measure and tobacco use inquiry.

So there's plenty to choose from to start reporting now. Report on individual measures. Still earn the quality bonus for your allowed charged, you know, with the 12 month period.

One thing if you wanted - if you want to go ahead and try to do this. One thing that you'll want to include in kind of your calculation of the measures to pick, and knowing a little bit about your patient population is the patients with the affected condition - whether they've been in already to see you in the first six month of 2008. And the likelihood that they will be in again in the second six months during which you would report the quality measure with that encounter.

So, if the patients are, you know, already identified as denominator patients the measure applies. But you don't have another opportunity to report on them in the last six months of 2008 even if the measure only needs to be measured once in the year. You won't likely have the opportunity, you know, it'll make a challenge to get to the 80% of the eligible patients. So, something to keep in mind.

The next slide, Slide 14 talks about the claims options that are available to you beginning July 1. And that's a major - this is a major focus of our presentation. This is the measure groups reporting option. And it's another reason for the timing of this Forum that we're holding now jointly with (CMS), that as we're just getting into July, and (CMS) has made this information available.

But we want to kind of reinforce that, and provide it, you know, directly to internists. And how it specifically most affects them. And we would - you know, (CMS) has done a really nice job of making a lot of information available on, you know, a program that's very broad in its breath.

And the role that we see (ACP) playing is kind of focusing some of that information to that it's most relevant internists to make it easier for you, kind of, to find the information that applies to you. And then go ahead and participate in the program.

So, the measure group option is now available. And a measure group is a group of individual measures covering a patient with a particular condition or preventive services.

And as I had earlier mentioned, that you can report on, you know, report the applicable measures in a measure group for 15 consecutive eligible patients.

Or you can report the applicable measures in the measure group for 80% of those eligible patients during the six month period.

This provide you another opportunity if you miss a patient, and when you're shooting for 15 consecutive patients. But you would likely - if you're going to reach the 80%, you're likely to start reporting the measure group early and in this last six months of 2008.

And you would certainly need to kind of report the measure group for the eligible patients through the remainder of the year. So, that's a good - even if you think you get to the 15 patients - consecutive patients. It's probably a good idea to continue to report on those in case you missed a patient in that string.

But also as, you know, valuable participation and experience with this type of reporting. So, you have this process in place to do it, you may want to go ahead and continue to do so for the remainder of the year.

But you should start that measure group reporting early. If you don't start so early, you can still certainly try for the 15 consecutive patients.

This does provide measure groups for, you know, more straight-forward reporting method, than reporting the individual measures on claims.

The reporting bonus for a claims-based measure group reporting is 1.5% of your allowed charges over the last six months of 2008.

I wanted to talk a little bit more about some of the measure groups. What groups are available? There are four of them. One is related to diabetes. And in that there are five individual measures.

Next is Slide 15. There's an (ESRD) here and say adrenal disease measure group that involves four measures - chronic disease, kidney disease group measure that involves four measures, and the preventive care measure group involves nine individual measures.

The denominator for the measure group is the same for all the measures in the group. So there's one denominator for the measure group, and that's based on, you know, (ICD), (ISCD 9) codes, as well as the age of patients that you see in your office. Primarily for measure groups.

There is, when you are going to report by measure groups - on Slide 16, there are - there is a - (CMS) has established (G Code). A specific one for each measure group that indicates your intent to report a measure group.

What you would do is you'd submit that measure group code, and then reply, thus the example of the code for diabetes is (G8485). And so you put that code on the first claim for the patient that you're submitting the measure group for.

And then you'd go ahead and list the individual quality codes that are applicable to that patient on that same claim form.

Moving on to Slide 17, you know, how do you go about determining if the patient fits the group? Just a couple pretty straight-forward steps.

The first being does the measure - does the measure group apply? And as I said that would be based on the (ICD) code that you're billing for the patient. Which in offices - in the (ICD) code and so like for the case of diabetes would be a diagnosis code and its 250 range that indicates diabetes.

Since the individual measure applied - each individual measure in the measure group does not apply to that particular patient.

So this depends on - can depend on the age of the patient, the gender of the patient, as well as the diagnosis.

And so, when we talk about a couple of these specific examples, it'll make it a little bit clearer how this fits in for each of the measure group.

We're going to talk about two of the measure groups specifically real briefly, as they're the ones that would most likely be used by the internists. Probably the general internists, and the first being the diabetes measure group.

And in that, Slide 18 alludes to the five individual measures that are kind of rolled-up into the measure group. So interesting about - I think the diabetes measure group is that all five of the individual measures apply to it - any patient that has the same - that meets the denominator criteria.

So that is that the denominator is the same for all five patients. And that's any patient age 18 to 75 with the diagnosis of diabetes that comes in for an office visit. So that makes it fairly straight-forward.

And then on Slide 19, this just a - kind of a graphic representation of that denominator information. Which I think again kind of illustrates that identifying your, you know, diabetes - the patients - your diabetic patients for which the diabetes group applies is fairly straight-forward.

The next slide, Slide 20 is just a screen shot of what a claim form would look like for the first patient in the diabetes measure group. So that would show that on the standard claim form in Field 24 of the claim where you would

report that the patient was in for an office visit - (JNR9213). You would list that - you would also list the (G Code) for the diabetes measure group to signal that you're reporting the diabetes measure group.

And then the individual measure codes for that - that apply to that patient. Which in this case would be all five. But you'd need to list the code for each of those individual measures.

As I said, there's some uniformity in the denominator area that makes this a little bit more straight-forward. You know your diabetics. You report your quality measure codes. Do it for 15 consecutive patients and you can earn your bonus.

For a typical internist it's probably pretty quickly for the number of Medicare diabetics that you have coming into the office. (ACP) is in the process of kind of developing a coding measure tool for the diabetes measure group where we want to lay all this information out on one page for you to see.

And then you can, for the patients with diabetes circle the appropriate quality measure code for each of the five individual measures, so. Look for that shortly. That'll be available through (ACP) Web site.

Now the other measure I'll quickly touch on is the preventive measure group. And you'll see on Slide 22, that there's actually nine measures in this - individual measures in this group.

And they span - have a range of prevention-related osteoporosis, urinary incontinence, the flu vaccine, pneumonia vaccine, (lamodorphy), colon cancer, tobacco use and kind of weight.

Some of these measures - where there's a little bit of complexity - a little bit more complexity for the diabetes measure group is that the individual measures applicability varies by the age of the patient, and the gender of the patient.

These are also - just pertain to office visits. So that's fairly straight-forward. And then in this case, there's no specific diagnosis covering requirements for the denominator, so. That's another piece that's pretty straight-forward.

The - this measure also has a group (G Code) to indicate the group measure reporting. And the - just to give you like an example of how the different measures can apply to different patients that - if you're patient is a male - on Slide 24.

It lists if your patient is a male age 65 to 80, that five of the nine measures in the group will apply. If the patient is female 65 to 69 all nine measures apply. And if it's a female patient age 70 to 80, then eight of the measures will apply.

This does provide somewhat of a challenge. And, you know, (ACP) is indicated on Slide 25 is working on a coding tool related to the preventive measure group that will intend to make it easier for you to - for the patient based on the patient's age, gender, to know which codes, you know, measure - individual measures you would need to report on.

And then to have the available codes to select from. In talking with some of the (CMS) Officials right before we started the call, Dr. (Green) of (CMS) had indicated that (CMS) will very shortly post what they're calling a PQRI Made Simple tool that will relate to this preventative care measure group.

And will hopefully provide bare bones information you need to know to record on this measure group. It's on the initial feedback that (CMS) received was that it was a little bit complicate and somewhat the far well - some of these folks call it.

That makes me I guess feel a little bit better as sometimes it can be a challenge to kind of walk through how you would, you know, report on this measure group with the volume of individual measures.

And from a (CMS) connect information available on all these measures - the four measure groups on its Web site and (Web 26 split). How you can go find that on all four of these group measures.

Just quickly in the interest of time, and I know you really want to hear from our individual members who are leaders in the College and participating in PQRI, and hear about their experience.

So, there are slides on the registry-based reporting option starting on Slide 27. As I said, these registries - just a way for physicians to report data and can be come essentially collected and then used for a variety of purposes.

(CMS) will soon announce the registries that they have selected that they can receive quality data from. And physicians who do report quality information to those registries will be able to have that registry report. Quality information on their behalf.

There are a variety of different options that reporting that information. Some can be reporting it over - on individual members. It can be reported on groups. It can be reporting on the full - you know, information for the full year. And information over the last six months of the year.

So, there are a variety of options that the payment will depend - the bonus then will depend on the duration of the reporting. (CMS) will make that information available in the registries.

They're registries that can record by August 31. The slide lists an example of a few of the registries that (CMS) worked to test this option with. And has no guarantee as to the registries that will be (afflicted). It gives you some insight to the type of registries that may be available or participate, so.

If anyone is reporting information to a registry and they're interested in getting credit for PQRI. What they should do is contact the registry. Find out if they did in fact self-dominate themselves to (CMS). And then inquire as to whether they believe that they did, they have a technical ability to report the information to (CMS) that (CMS) needs.

And if you can express your interest in having your (nator) reported to the registry, so. Some of that information's too early to point out. And that's why we wanted to focus on the claims option.

The next few slides - I'll talk - the next few slides talk about the steps in the reporting process. Michael touched - Michael Rapp touched upon these earlier.

And this kind of just spans the - being (inhibit) of how you go about selecting the measures. You know, having your teenager - care teen and define the rules of those team members. Identifying patients, using coding tools that are available to you and making sure that information submitted - using it then to assess your performance. And you may want to do that yourself without

waiting on the feedback from (CMS) as it kind of takes them some time to get your feedback on your 2008 performance.

This is the type of thing that we'll be hearing from the members Dr. (Hornback) and Dr. (Newman) very shortly. So, I'll let them talk about the steps - their steps in the reporting process and how they found it - you know, doable to report this information.

The Slide 32 and Slide 33 talk about some of the resources that (ACP) currently makes available to assist members and participating in the PQRI Program. That screen shot is a coding tool that we make currently available. It's on Slide 32.

Slide 33 is our clinical decision support platform that has information on the evidence related to over 300 conditions, but also has a specific quality measure section that has the evidence related to all the PQRI measures.

So if you want to go on that, you can drill down to the level of detail you want to find out the clinical - say clinical evidence related to all the individual managed measures. So that took some time to put together. It's a real nice tool. And it's available for free to (ACP) members.

Now I'd like to turn it over first to Dr. (Rodney Hornback) who is in practice in Connecticut, and is a member of the (ACP) Performance Measurement Committee that's opened the bar on these issues. And he has been participating in PQRI.

When he finishes describing his experience, he will turn it over to (Mary Newman) who's in practice in the Baltimore area and participate in PQRI.

Both of them are in relatively small practices, and you know, can, you know, hopefully provide you some information that'll be helpful to you as you consider all of your options.

Following that will be a question and answer period in which the (ACP) staff here, as well as the members will be available to answer questions. And we have Dr. Rapp and Dr. (Dan Green) on the line from (CMS) that will be able to help out as needed as well.

As you see on Slide 35, I mentioned there is a - there's actually an email - a mailbox that - related to PQRI that (ACP) created that members can submit questions. So if you have any questions that you'd like to ask after the call, or we don't get to during this session, feel free to use that.

And then there's a link to a survey that's available through the (ACP) Web site that you can give us feedback on what you thought about the value of this call. As well as, we have some general questions about your experience in participating in PQRI.

So we'd ask that you take the time to quickly do that. It's very brief. It'll just take you maybe two minutes to complete. And that feedback would be very helpful to us, so. Thank you for your attention and now we'll kind of get to the best part of the show here, and that would be hearing from your colleagues about how they're participating in the program.

So, Dr. (Hornback)?

(Hornback): Yes I'm here Brett.

Brett Baker: Great.

(Rodney Hornback): Well I wasn't sure, as this program was rolled-out in 2007, whether it would be worth the effort to participate. But I decided to try it out and see what happened.

And I chose the diabetes measures which are the hemoglobin (A1C), the LDL cholesterol, systolic and diastolic blood pressures. So there are four sets of (G Codes) that have to be used.

I developed a list of patients who were Medicare beneficiaries with diabetes simply by doing a report from my practice management software system. I use (Mysis Tiger).

And I developed a worksheet that included the four measures. It's the four includes the two blood pressure measures. And just checked boxes for which (G Code) was appropriate for each patient.

And as the patients came in for visits, my staff put the worksheet along with the encounter form, and we worked it right into the normal workflows. So as I was checking off (99213) or (99214) for the visit, I was also checking off what their last hemoglobin (A1C) was and what their last LDL cholesterol and blood pressure and so forth.

And then I taught the staff to enter those (G Codes) in conjunction with the other chart's codes attached to that particular encounter.

At the end of the year I asked my self the question - was it worth it? And I simply did a report out of the practice management system querying the (G Codes) that were used.

And I then multiplied the total projected Medicare billings for 2008 times the 15% and divided it by the 82 unique patients that were reported on in 2007.

And in my practice as an internist in geriatrician, a substantial portion of my revenue actually does come from Medicare. So that was - that figure is around $200,000 a year in total Medicare receiving.

And 15% of that is $30,000 - excuse me $3,000. And then divided that by 82 unique patients and you get a figure of $36.58 per page completed and claim submitted.

So if you put that into the rank order of other services, it's more valuable to the practice in terms of revenue than electrocardiogram, and slightly less valuable than a (99212). And a little more than 1/2 of what is received for a (99213).

So of all the things that I do, that was the some of the easiest work that I did to earn that fee. So I think converting in your mind to a fee-for-service equivalent, puts this into perspective.

Once it's set up it's - it runs itself. It's on auto pilot. It was easy to remember to do it - to start the process again when January 1st rolled around.

Now the actual effort for 2007 was actually half that. Because it was .075% because it was only a six month period.

You can flip this analysis around and you can envision a practice that has only $50,000 in Medicare visits. And has 200 diabetics. And if you do the math there - $50,000 x 15% divided by 200 works out to $3.75 per patient reported. And that's clearly just not worth the doctor's time.

So I think it's dependent upon the individual practice. The 15 patients - the 15 patients in the treatment - in the group - the diabetes group - the reporting on some additional measures on 15 consecutive patients with diabetes, that changes the calculus considerably.

$3,000 divided by 15 patients is $200 per patient reported on. Now that begins to look like - well worth one's effort. I mean easily worth one's effort to report.

So that's an option that makes financially more sense. I wish I hadn't started reporting the other way on January 1st for this year.

So that's my experience. I'll turn it over now to (Mary Newman). (Mary Newman) are you on the line?

(Mary Newman): You hear me?

Natalie Highsmith: Yes we can hear you now.

(Mary Newman): Okay. I'm (Mary Newman). I'm in a 14-doctor group Internal Medicine and Internal Sub-Medicine/Sub-specialists in Lutherville, Maryland.

Our practice - with the help of our practice manager decided to do diabetes and coronary artery disease. We picked those measures because they were memorable to the doctor, so and their patients who tended to be more than once a year. So it gave us more chance to hit them one, two or three times during the reporting period.

We made - we left it to the physician to figure out who needed to be reported on. We had a paper that the doctor just kept at their desk. And it was really for coronary disease a single check mark to make sure that they were on oral anti-platelet therapy.

Or in the case of hemoglobin (A1C), the LDL, (lipo protein) control or high blood pressure control and Type 1 or Type 2 diabetes, you could check up to - you have to do I think up to four check marks.

So, you know, it was simply a matter of writing a patient's name on a form, putting a date on it and attaching it to a super bill that had the appropriate code. And we do all our diagnosis coding.

So I figured it took, for the diabetes ones, it could take 30 seconds to two to three minutes to check back through their record and find the last LDL cholesterol and hemoglobin (A1C). The blood pressure of course I just got the data because I just saw the patient.

And so, it was pretty simple. It was quick. It made me think about my performance over longer period of time. I did sometimes to my horror notice that there were patients I really hadn't checked something on. They always had afternoon appointments, so they never got fasting cholesterols or I didn't know what anti-platelet drug they were taking since the cardiologist was managing them.

So I did find some things. Usually in the diabetic patient in which I found things, it was because they were too sick or something else. So those are actually people who you can just check off as being inappropriate to check those or monitor those findings.

So, you know, I think my partners, because most of my partners decided not to do it. Thought it was more burdensome than it actually turned out to be. The only problems I saw while trying to do it was that I sometimes forgot. So because most of the patients were seen - the diabetic patients were mostly seen twice during the time period, I usually caught them on the next visit.

It is distracting. Sometimes I would forget to do a prescription or write a referral for something because I switched gears. The immediacy of office visits is very immediate.

And I think we can only hold three to five things in our working memory. And this is another one. If - I don't know what my payment is. We started to view the payment access yesterday. And it's a fairly long back and forth thing to get access to the Web site. So, hopefully when I find that out I'll know how much it seemed worth doing.

I would have liked more on-going feedback about my performance during the time period. But I think that it wasn't difficult. I helped me switch to thinking about registry thinking.

My (EHR) - my electronic health records wasn't sufficient to automatically generate reminders. So it was dependent upon me. So I would agree with Dr. (Hornback's) estimates on approximately what I think my revenue will be, which will be I believe $3,000 more or less for having done this.

I think I did between three and five reports a week. So it wasn't that burdensome. The biggest problem was remembering to do it. Although it seemed to get much easier over time.

Brett Baker: Thank you to both of you for putting that in terms that I think would be, you know, very understandable to your colleagues. And we do appreciate you sharing your experience.

And I guess we would - I guess I would first before we kind of move on to the question and answers, and I believe Dr. (Hornback) and Dr. (Newman) can participate in that as well.

I'd ask, you know, (CMS) if they wanted to make any comments related to some of the issues that were raised. I think right before we started the call we were talking with Dr. Rapp about registering for the secure online system.

And so I think they are, you know, (CMS) is kind of getting some experience with the physicians and the practices taking that step. So I guess Dr. Rapp do you have any comments before we move to the question and answer period?

Michael Rapp: No. I think that those were very helpful vignettes of how two different interests have dealt with the program. And I was quite intrigued.

With regards to the feedback reports, I think ideally yes it would be nice if we could have more frequent feedback reports. I would just say that the feedback reports were not actually a requirement of the statute.

The statue required us to make payments based upon a reporting, but we felt that the feedback reports are very important aspect to it. And so we incorporated it - that into the program.

As time goes on, possibly we'll be able to have more frequent feedbacks. But certainly from a practical standpoint, implementing in the first year we're pleased that we were able to get this up and running as it is.

And then as time goes on, the registering for the reports using the secure online system is probably the most daunting aspect of getting the reports. That really only has to be done once though. I think that's the most important thing. You have to get a key to the house once.

But once you've got that key you can go in anytime and you can go in for multiple purposes. And we would expect that one will have to do that, as one will find that entry way for a variety of other Medicare purposes too.

But, thank you very much for those vignettes. Again, I thought they were quite intriguing to hear the personal experiences.

Brett Baker: Thank you. And Natalie I believe we are now ready for questions.

Natalie Highsmith: Okay. (Laurie) if you can just remind everyone on how to get into the queue to ask a question or give their comment. And everyone please remember when it is your turn, to re-state your name, what state you are calling from and what provider or provider organization you may be representing today.

Operator: Thank you very much. I would like to remind everyone to signal for a question, please press Star 1 on your telephone keypad.

Again, to signal for questions, please press Star 1 at this time.

Our first question comes from (Kathy Ellis).

(Kathy Ellis): Hi. I'm calling from Charlotte, North Carolina. I am not in Internal Medicine, but I wanted to ask a question. I missed the last Forum. If you have a question

on how to report for your specialty because there seems to be a discrepancy in some of the measures - (101 to 105). Who do I contact?

Brett Baker: The question would be related to the reporting of specific measures in the list of 119. The measures - this is Brett Baker with (ACP) and (CMS) may want to add to my comments.

I think the measures aren't technically, you know, limited to certain specialties, but I think if you have - if you have questions related to how to use certain measures in the list, that you could probably get a sense.

I don't have the full list in front of me of those measures. What are the specific clinical area that - which you're referring to?

(Dan Green): This is (Dan) at (CMS). I believe those were the prostate measures.

(Kathy Ellis): Yes sir.

(Dan Green): Yeah. Was your question about how to report the measures? Or exactly what are you trying to find out?

(Kathy Ellis): On one of the measures for me it says to report it each time a patient has treatment. And in a free-standing (radiology/oncology) center we report both (77427) and the (antigen) code. So am I supposed to report on every single one?

And then what about the denominator? If we are not supposed to report for prostatectomies, doesn't that make our denominator higher and mess up our (met) numbers?

(Dan Green): To be honest with you, I'm sorry I don't have the specifications right in front of me. But it'd be my pleasure to look into this for you if you want to send me the question.

(Kathy Ellis): Okay.

Man: Or do you want to give us your phone number and we can call you?

(Kathy Ellis): I'd rather email if that's okay?

Man: Okay. You want to give us your email address?

Brett Baker: If you send it to pqrifaqs@cmsofhhs.gov.

(Kathy Ellis): Okay.

Brett Baker: It will come into our mailbox. And we will try to get you an answer in the next couple days.

(Kathy Ellis): Thank you so much.

Brett Baker: Thank you.

Operator: Our next question, we will go to (Carmella Knockrunner).

(Carmella Knockrunner): Hello. This is (Carmella Knockrunner) from Pittsburgh at UPMC Health System. I'm calling about the 15 consecutive patients. If I'm trying to assist a physician group to do that.

What if they had a patient in between the 15 that has Medicare as a secondary insurance? Does that count as well? Or should we skip that patient? Or should we just send that data in just in case the original - the primary insurance is denied? It's disconnected. I can't believe it.

Operator: One moment.

(Carmella Knockrunner): Oh I thought I was disconnected.

Man: So.

(Carmella Knockrunner): I didn't hear anything I'm sorry. I just kept hearing a phone ringing.

(Bret): Yeah I'm sorry this is (Bret) with (AT&T) and that was a technical issue on our end. It's now resolved.

(Carmella Knockrunner): Do I need to repeat my question?

Brett Baker: We didn't hear it here, but if the folks from (CMS) did and other did, if they want to respond first?

(Carmella Knockrunner): Okay.

Brett Baker: But if it gets directed directly to us you'll need to repeat it.

Operator: Okay. Hold on one second.

(Carmella Knockrunner): Sure.

Michael Rapp: So I think we're not exactly stumped by the question, but it has to do with the processing of the claims information?

(Carmella Knockrunner): Right.

Michael Rapp: So if we get it in then we would of course consider it. I think from a practical standpoint you should go ahead and report it on the claim. But probably - I would probably report it, but then also go ahead and count 15 where you actually have Medicare as the primary one.

But, we'll try to get a more definitive answer on this and put it up on our frequently asked questions.

(Carmella Knockrunner): Okay. And also just, I do have my 15 consecutive patients. I've been monitoring them coming in on the schedule. Do I have to keep those schedules as verification? Is that something that you're going to be like assistant - I don't know? How do I?

Dr. Rapp: We're not going to do that.

(Carmella Knockrunner): Okay.

Dr. Rapp: The way we're going to figure out is we're going to look at the consecutive patients by date.

(Carmella Knockrunner): Okay.

Dr. Green: Date of service. So if you see 20 - if you see 20 patients on the same day, we wouldn't know really if you skipped on or another if you only reported 15 if they were particularly in order.

But the definition of consecutive is by date of service.

(Carmella Knockrunner): Okay. So if I had 15 on - if I had 10 on day and five on the next day. If that's how it's going to be.

Dr. Rapp: That's how it's going to be. But if you have 10 on one day and 10 on the next day, we stopped. You only report five on the second day. It could be that of those 10 you report, that you don't get everyone in order. But we're not going to look to that level of detail.

(Carmella Knockrunner): Okay.

Dr. Rapp: We don't have that information. All we have is the date of service, so.

(Carmella Knockrunner): Okay.

Dr. Green: But back to your original question. If it's not too much trouble, to be on the safe side, as Dr. Rapp said, I would report on the one that has the other insurance company as the primary payer and Medicare as the secondary.

But if you can, for safety's sake I would report on a 16th patient.

(Carmella Knockrunner): Okay.

Dr. Green: Just in case the primary insurance company somehow strips off its quality data codes and we don't receive it because, you know, we hate for you not to pass because of something out of your control.

(Carmella Knockrunner): Okay. Thank you.

Dr. Green Thanks.

Operator: Our next question comes from (Diane Weiss).

(Diane Weiss): Hi. Good afternoon. This is (Diane Weiss) at (Ostra Health System) in Louisiana. And first of all I just wanted to say thank you for making all of this information available. Implementing a program like this certainly can be a bit challenging.

I did want to especially thank you all for the - for the information on the July 9th phone call about accessing those reports. As I still continue to work to get some of our providers involved, we are anxiously awaiting for the feedback from the ’07 reporting period.

And I’m having a difficult time finding that presentation. There was some specifics that you all presented on July 9th about accessing those reports that I’m not able to put my hands on.

And wanted to know if you could check the PQRI section of the (CMS) Web site to see it it’s there? Or if I’m just missing it, perhaps you could provide some clarification before the end of the call?

(Pam Frederick): Hi this is (Pam Frederick) from (CMS). We have temporarily taken down that slide set from the PQRI Web site because we needed to make some corrections to the Power Point slides.

And rather than have mis-information up on the Web site we chose to take it down until we can correct the set and get it back up on the Web site. Hopefully by the beginning of next week we will have re-posted the slide set.

(Diane Weiss): Great. Well I'm glad to hear that. I thought maybe there was something I was missing. And encouraged to know that it's just actually not there, but will look for it next week. Thank you all very much.

Operator: We'll take our next question from (Bea Malek).

(Bea Malek): Hi. This is Mrs. (Malek) from Dr. (Malek's) office. First again also I'm happy that you have taken this measure. Because this is an endocrine office and we do, you know, have all this. We are always doing this measure.

I wanted to know for diabetics, do we need to have all the five measures that are mandatory? That is my question.

And also the three claims based that you are doing, does it have to be like say we are doing from July through December. So our first roll-out patients will be going the first week of July.

And then they are not seen after three or four months. So how do we do all the three claims within that period?

Brett Baker: This is Brett Baker and on the first part of the question about the diabetes measure group.

(Bea Malek): Yes.

Brett Baker: In all five of the individual measures in that group, and (CMS) can respond as well, but my understanding is that since the denominator is the same for all the individual measures in the diabetes measure group, that you would be

typically be reporting on all five individual measures when the patient is eligible for the group.

If the -if one of the individual measures was, you know, not applicable or just more commonly, you know, it's something that you'd report an exclusion for as to not being relevant or not done. Then you can use the exclusion modifier for that individual diabetes measure code.

So I believe that's the answer to the first question. The second, which I'm not sure I understood correctly, but was whether the patient would come in - in July and then the same patient would come back, you know, three months later or later in the year.

For the measure group, you would - if you were, you know, going for the 15 consecutive patients, you likely wouldn't need to report on that second encounter with the patient.

But if you wanted to as a back up or go for that 80% of the measure group in the last six months, then you would report on that patient again. And then for the individual measures in that measure group, you would kind of pick up appropriate quality measure for each code. Which include that, you know, re-reporting that you had, you know, already checked the hemoglobin (A1C), or, you know, whatever the appropriate individual, you know, quality measure code would be for each individual measure.

(Bea Malek): Okay. So it does not have to be like, you know, the second time they're coming, you may not report it? Or you have to report the - how they are doing the second time?

Michael Rapp: This is (Mike) Rapp from (CMS). The way the diabetes measures work, they only have to be reported once during a reporting period for a particular patient.

(Bea Malek): I see.

Michael Rapp: So once you report it on a patient with diabetes, you're done with them. You can report again. There's no penalty for that, but it's not necessary.

(Bea Malek): So what does that mean with three claims based? I don't understand that?

Dr. Green I'm sorry (Mike).

Michael Rapp: No. On three claims based - you're talking about three measures?

Mr. Baker: I think the confusion you have Mrs. (Malek), if you're intending to start reporting in July using claims. The options that you have are reporting the diabetes measures group which would require you to report on all five of those measures for either 15 consecutive patients, or for 80% of the patients that Dr. (Mallic) sees during that six month reporting time.

The three measures that you're referring to is only an option if you're reporting for the entire 12 month reporting period. Or, if you're reporting through a registry.

(Bea Malek): Thanks. That answers my question.

Dr. Green Yeah Mr. Baker thank you.

Operator: Our next questions from (Michael Davisworth).

(Michael Davisworth): Yes this is (Michael Davisworth) calling from Scottsdale, Arizona. The provider I work for is Dr. (Paul Howard). Dr. (Howard) wanted me to sit in today to see if this would be something he'd be interested in doing.

And the only question I have is Dr. (Howard) is a Medicare non-assigned provider. How does this affect payment if it does at all?

Mr. Baker: You say he's a non-participating provider?

Dr. Rapp Mr. Baker I'm going to let someone from the payment end answer that question.

(Kathy Purcell): Hi. This is (Kathy Purcell). I'm assuming you're an enrolled Medicare provider, but you've elected not to accept assignment on your Medicare claims.

(Michael Davisworth): That is correct.

(Kathy Purcell): It shouldn't have any impact on the people - your PQRI payments. It doesn't matter if the claims are assigned or unassigned. It's just that you have to submit the claims with the proper measures.

(Michael Davisworth): Sure. Okay. That was the only question I had. Thank you.

(Kathy Purcell): You're welcome.

Operator: Our next question comes from (Carol Cooper).

(Carol Cooper): Hi. This is (Carol Cooper) from (Inland Imaging) in Washington. One of the questions I have is what of the new measures are specifically for radiologists?

Woman Does anyone at (CMS) want to respond to that question?

Michael Rapp: Is the question what measures are specifically for radiologists? Is that what you said?

(Carol Cooper): Correct. The new ones. We are currently doing measure 10 and 11.

Michael Rapp: Okay. The new ones - they're - are you talking about for measure groups?

(Carol Cooper): Yes.

Michael Rapp: So there are no new measures that were introduced in July of 2007. The measures for - excuse me, for 2008. The measures for 2008 were - are the same 119 measures that were identified previously.

The only thing that happened mid-year is that we have different alternative reporting criteria for measure groups.

So, we identified several sets of measure groups - diabetes, end-stage renal disease, chronic kidney disease and prevention.

But the - none of the measures are especially specific. However, it would be unlikely I would think that the radiologists would have practice that focuses on those types of services.

But the measures that you're talking about that were already, you know, stacked for 2008 continue in effect. And just - and the introduction of the

measure groups gives another way - another set of criteria by which the bonus payment can be earned for 2008.

But those - for physicians and other professionals that are already reporting using a particular method for individual measures, there's no reason or no need to change. Just keep the reporting up to meet the 80% requirement.

(Carol Cooper): Okay.

Michael Rapp: Does that answer your question? Or did I not?

(Carol Cooper): Yes. Yes you did.

Michael Rapp: So if you're already reporting on two measures, just keep it up.

(Carol Cooper): Okay. Thank you.

Operator: From (Yvonne) we take our next question from (Rita Barilla).

(Rita Barilla): Hi. The question that I had is what (G Codes) are you actually using on the PQRI? Is it just (Ep Codes)? Because we weren't billing any (G Codes) with ours.

Dr. Green Could you repeat that?

(Rita Barilla): With the PQRI, we wanted to know what (G Codes) are you actually billing out. Because I know that we're billing the diabetic patients, but we're not using any (G Codes).

Michael Rapp: Okay. Are you familiar with how the program works in terms of re-submitting a quality data code for the measures? Or are you talking about using measure groups?

Just briefly. The (G Codes) for measure groups are to indicate the report - the starting of reporting measure groups if that's what you're talking about. There are (G Codes) for that.

(Rita Barilla): That's what I'm talking about. Exactly. What codes should I be using?

(Dan Green): Okay. So I'm sorry this is (Dan). I don't mean to just speak over Dr. Rapp. But are you currently participating with PQRI and submitting quality data codes?

(Rita Barilla): Yes we are.

(Dan Green): Okay. So the three measures - I'm sorry, that you're referring to I believe use (CPT 2) codes which end sometimes in an (F).

(Rita Barilla): Okay. We're using those. Okay.

(Dan Green): Right. So not all measures have (G Codes). The (G Codes) that we're referring to when we talk about measures groups, there is a specific (G Code) with each measures group. So, if you started to do the consecutive patient part, and again if you're already participating with the three measures through the claims from the beginning of the year you should not change.

Because you'll only qualify for the six month reporting as opposed to 12 month which could lower your potential incentive payment.

So if you're already doing three measures through claims, the codes that you're talking about ended in (F). Those are (CPT 2) codes. (CPT 2) codes and (G Codes) are both used as quality data codes to report information to us.

Measure specific (G Codes) are a - I'm sorry, measured group-specific (G Codes) are to indicate to (CMS) that you intend to report the diabetes or the end-stage renal disease or preventive care measures group.

And it signals us that this is the start of your consecutive patients, or this is the start of your report of that measures group for the 80% consecutive patients.

So if you're submitting that (F Code) as you called it, that is a (CPT 2) code and that's fine.

(Rita Barilla): Okay. Another question that I had is we currently have these code on a Hicfa and on the electronic, and we're not - we don't have a separate note for them. Are we doing that correctly, or should the doctor be noting a separate note?

(Dan Green): Separate note on the claims?

(Rita Barilla): Yes. A separate progress note. Because we're combining everything like with (EN&M) and we're submitting it electronically.

(Dan Green): That should be fine provided that the (EN&M) service - that the measure is - calls for is included as well as the diagnosis.

So in other words, for diabetes you'd need to have let's say a (99213) and I believe it's a (250.something) I believe for the diabetic (ICP) codes.

So as long as you have that information on the claim with your quality data codes - those (F Codes) as you refer to them. You should be good.

(Rita Barilla): Great. Thank you.

(Dan Green): Thank you.

Operator: We'll take our next question from (Hila Austrin).

(Hila Austrin): Hi. This is (Hila Austrin) from Dr. (Donald Austrin's) office in Connecticut. Someone actually just put on it - I was under the impression that you needed to have it documented in the - we have an electronic health record through (e-clinical works).

And my husband always checks everything. And he is writing a separate note saying, you know, reviewed the hemoglobin (A1C) and it's below 9 and whatever. Is that necessary for him to be doing? Or does he just review it and write down on the claim that he's reviewed it? I guess should it be documented in the notes also that it was reviewed?

Michael Rapp: In general you should - the submission of a quality data code on the claim is simply a reflection of what was done. So normally you would document your services in general.

(Hila Austrin): Okay. Well he documents the (EN&M). It's just those specific measures. I wasn't sure how far he needed to get into it.

Michael Rapp: These particular measures that you are describing, you know, he would have had to checked the hemoglobin (A1C) to know which of the (CPT 2) codes to report. Whether it's above 9, between 7 and 9, or below 7.

(Hila Austrin): Right.

Michael Rapp: Similarly for the blood pressure, there are different codes for the pressures. So he would need to have documented it to be able to report the code that's correct.

Dr. Green But let's say you've got the laboratory results in the chart.

(Hila Austrin): Yeah that's what I'm saying. Like the hemoglobin say might be three months old.

Dr. Green If it's in the chart, I don't think you probably - I mean the documentation we don't have specific rules or requirements for documentation.

(Hila Austrin): So that's he's looked at it and then we're reporting it on the claim with the proper (F Code) is okay?

Dr. Green Right. All we'll see is the codes. We don't seek to get into details about telling you how to document your care.

(Hila Austrin): Okay. Now last year we did - we were doing the 80%. Our health record - our (EMR), it popped up everything. They had a PQRI tool. So we were making it a lot harder than we needed to.

I mean we would report on falls. We would report on end-stage renal disease and diabetes. Whatever it came up with we were reporting it every time which I now see we don't need to do that.

So for the first six months of this year, I just said enough. I can't spend an hour on a Medicare claim. And neither could he. So, shall I for the rest of the year just do the 15 80% with the group/

Dr. Green No. Again, the 15 consecutive patients for the measures groups only applies to the second half of the year.

(Hila Austrin): Right. But this - the beginning part of this year I didn't do it. I did it for last year and I just stopped for like six months.

Dr. Green So you did 10 measures last year and you just said enough and.

(Hila Austrin): Exactly. And now my husband - actually he didn't know I stopped doing it. But I stopped.

Dr. Green Well we won't tell, but the other 100 and some people might.

(Hila Austrin): Yeah.

Dr. Green Now everybody knows. So, yes. Once you have available in a claims-based system would be to use the measure groups.

(Hila Austrin): Okay. That's what we will do then. Okay. Thank you very much. It was very informative.

Operator: We'll take our next question from (Amy Lind).

(Amy Lind): Hi. My name is (Amy). I'm calling from a Pain Management practice. Obviously none of the measure groups apply to our practice, so I will be reporting individual measures.

I've come up with about four measures that I think would apply to us. Should I report all four measures even though one or two of them don't apply? Would I report that measure with the exclusion modifier? Or do I just don't report the measure on the patients that it does not apply to?

Dr. Green The way it works is to earn the 80% incentive, one is required to report on three measures if three apply. Or if less than three apply, then one or two measures as applicable.

So, there's a validation process that if you report a measure and there's one closely related - like if you only reported one diabetes measure, that you would not be able to qualify for an incentive payment by doing that. Because there are two other measures at least that are applicable.

But, you have to pick the measures that you think are applicable to the practice. There's no point in reporting a measure that's just not applicable to the service. So, the ones that are applicable and you report up.

One caveat here is you talked about starting now. Of course, the requirement is 80% of applicable cases. So in certain instances, the measure - and you can look at the individual measure you're talking about.

And if it's a measure that only has to be reported once during your reporting period, and some 60 of the measures are like that. Then you could conceivably be able to qualify even though you're starting late in the year for that particular measure.

But, if it's a measure that has to be reported on each visit, for example, aspirin with a heart attack. Every time the person has a heart attack. Or antibiotics

pre-operatively. Every time you take - do a patient - if you do 10 operations on that same patient, you would report each time.

But as I mentioned earlier, diabetes is just once per reporting period. So you have to look through it and see whether you can effectively report.

Even if you don't earn the incentive though, if you decide you want to see how it works and see how the information would come back. Even through you don't qualify for the incentive, you will still get a report next year.

And so you may want to do that just to see how it works and to get the report back. Even though you may conceivably not actually qualify for the incentive payment.

(Amy Lind): Thank you. I use a structural measure. Or should that be in addition the one, two or three measures - quality?

Dr. Green If the structural measures are alternatives, once you report a measure once, it's assumed it applies to you.

So you would with a structural measure - the difficulty there if you're starting this late in the year, that basically is an every time kind of measure.

So, unless you're seeing 80% of your patients after today, it would be unlikely that you'd get a satisfactual report.

But nevertheless, couple of aspects to that. The structural measure for (e-prescribing) as you know, probably in the new Medicare legislation - that we don't know what the status will be since the President vetoed the particular Bill that was recently passed.

But if that provision that was in there, it provides a 2% incentive payment for (e-prescribing) for 2009. So you might want to get used to reporting that measure even though you conceivably wouldn't qualify for an incentive payment this year. But you would figure out how does that measure works next year.

And if Congress moves ahead and the same legislation comes through with that provision in it, that's a particularly important opportunity to earn an incentive. And also to promote (e-prescribing) which we believe has a lot positive benefits from point of view of patient safety and also patients.

(Amy Lind): Okay. Thank you.

Operator: Our next question comes from (Kian Kaflin).

(Kian Kaflin): Hi this.

Operator: Ms. (Kaflin) please check your mute button. We cannot hear you.

(Kian Kaflin): Hi this is (Kian Kaflin). I work with (Radia) in Washington. And I do have a question about the new measures for big - we're the largest radiology group in the Pacific Northwest.

So I have a question about the new measures (T144) and (T145). How do we go about participating in that? Even though I know it's not an incentive.

Dr. Green All you have to do to report those measures is just go ahead and start reporting them. And then we will be able to evaluate the participation.

So we would encourage you to do that. I think it's one that's - those measures are probably supported by the Radiology Association.

And so, to participate with that, all you have to do is just submit the relevant (CPT 2) code.

(Kian Kaflin): (C Code) you mean?

Dr. Green Pardon me?

(Kian Kaflin): You would submit the relevant (CPT) codes?

Dr. Green Yeah. (CPT 2). You report those measures the same way you do every other regular measure. The only difference is they don't qualify for an incentive payment. But you don't.

(Kian Kaflin): Okay. But you report it under the (CPT) Category 2 code?

Dr. Green Just the way you do the other measures. Yes.

(Kian Kaflin): Okay. Thank you so much.

Natalie Highsmith: Okay, well we have reached our 5 o'clock hour here on the East Coast. I would like to turn the call over to our presenters for any closing remarks.

Brett Baker: Oh great (Deb), thank you. This is Brett Baker with (ACP). And thanks to all for their participation and (CMS) for sticking around and helping to answer, you know, many of the questions.

I hope they're helpful to the other participants as well. And just to kind of reiterate that any questions that we may not have got to, the last slide in the slide deck contains our PQRI mailbox that you can send questions directly to (ACP).

And I believe you heard from (CMS) as they had briefly had mentioned the mail box - the email box that they have for PQRI questions. So we certainly encourage you to submit questions and that we can respond to and use the kind of broad - more broadly inform our members about the issues that are likely, you know, that you would have that are representative of the larger group.

Also, again, we'd ask that those participants go to the - our Web site and fill out the very brief survey on their experience with this call. And then PQRI participation in general.

So, the (ACP) was delighted for the opportunity to work with (CMS) to co-host this Forum. A special thanks to our (ACP) leaders who shared their experience.

And we intend to kind of catalog those and other kind of experience - success stories and make those available, and other information on the PQRI - on our Web site to help our members, you know, that are more interested in participation and participating in 2008.

And then in 2009 as the Medicare Program is likely to continue to be funded and probably even with a slightly larger payment than before, so. Again, thanks to all for their participation.

Dr.Rapp And we would say - like also from the (CMS) standpoint to express our appreciation to the American College of Physicians. And your participants. It was a very informative call. So thank you all.

Natalie Highsmith: Okay (Laurie) can you tell us how many people joined us on the phone lines?

Operator: I have 212 today.

Natalie Highsmith: 212. Okay. Thank you all. And please stay tuned to the Open Door Forum (List Serve) for announcements for any upcoming Open Door Forums related to PQRI. Thank you.

Dr. Green Hi - hello? Hello?

Dr. Green Hello?

Dr. Green Hey this the (ACP call).

Dr. Green Hi. We're just trying to find out from the operator how many folks still were in line for questions.

Dr. Green Oh okay.

((Crosstalk))

Operator: Thank you very much ladies and gentlemen for joining today's Centers for Medicare and Medicaid Services Conference Call.

This concludes your conference. You may now disconnect.

END